Washington State Health Care Authority

# Medicaid Expansion 2014

## Application for Health Insurance Stakeholder Review

Mary Wood, Section Manager
Health Care Authority
Eligibility, Policy and Service Delivery

# Today's Agenda

- Review drafts:
  - Application for Health Insurance
  - Line Instructions for Application
  - Supplemental Application for LTC/ABD
- Welcome your input in creating a simplified and streamlined application
- Review each section & take notes

# Application for Health Insurance PART 1

- Name and Contact Information
- Interpreter Information
- Residency Information
- Incarceration Information

# Application for Health Insurance

**Name and Contact Information**

1. FIRST NAME | MIDDLE INITIAL | LAST NAME | SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE (REQUIRED)

2. ARE YOU HOMELESS OR WITHOUT A FIXED ADDRESS? ☐ No ☐ Yes IF YES, GO TO QUESTION #4 AND PROVIDE A MAILING ADDRESS.

3. ADDRESS WHERE YOU LIVE | CITY | STATE | ZIP CODE

4. MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE

5. PRIMARY PHONE NUMBER ( ) | SECONDARY PHONE NUMBER ( ) | E-MAIL ADDRESS

The Exchange may need to contact you regarding the status of your application and/or request additional information.

6. What is your preferred method of contact? ☐ PHONE ☐ EMAIL ☐ USPS MAIL

**Interpreter Information**

7. Do you have trouble speaking, reading or writing English and need an interpreter? ☐ No ☐ Yes What language or alternative format do you need? _____

**Residency Information**

8. Is everyone applying for health insurance a Washington State Resident? ☐ Yes ☐ No If no, list who is not a resident:

**Incarceration Information**

9. Are you or anyone in your household residing in a city or county jail or a state or federal prison? ☐ Yes ☐ No If yes, enter their name:
Enter their release date if known

# Application for Health Insurance PART 1

- **Demographic / Tax Filing Unit Information**

# Application for Health Insurance

**Demographic / Tax Filing Unit Information (See Instructions)**

A tax filing unit is yourself, your spouse, and anyone you expect to claim as a dependent on your tax return. Complete this section even if you do not expect to file a tax return. Do not complete the last two columns on the right in the table below if you are purchasing unsubsidized health insurance through a Qualified Health Plan (QHP).
*Race Code: W=White; B=Black or African American; A=Asian; N=Native Hawaiian; P=Pacific Islander; O=Other

| 10a: NAME (FIRST / M.I. / LAST) (use more paper if needed) *RACE CODE (OPTIONAL) | 10b. CHECK IF YOU WANT HEALTH INSURANCE FOR THIS PERSON? | 10c.. SEX M/F | 10d. RELATION TO YOU (I.E. CHILD, DOMESTIC PARTNER, SIBLING, GRANDCHILD) | 10e. DATE OF BIRTH (MO/DA/YR) | OPTIONAL FOR NON-APPLICANTS | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 10f. SOCIAL SECURITY NUMBER (SSN) OR DEPARTMENT OF HOMELAND SECURITY (DHS) ID NUMBER | 10g. CHECK IF U.S. CITIZEN | 10h. CHECK IF DOCU-MENTED ALIEN | 10i. CHECK THE BOX INDICATING THE TAX FILING STATUS FOR LAST CALENDAR YEAR See Instructions | 10j. CHECK THE BOX INDICATING THE EXPECTED TAX FILING STATUS FOR THE CURRENT CALENDAR YEAR See Instructions |
| **10.1:** Primary Applicant First/ M.I. Last Race Code | ☐ | | **SELF** | | SSN DHS ID | ☐ | ☐ | ☐ Individual or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Tax Dependent ☐ Non Filer | ☐ Individual or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Tax Dependent ☐ Non Filer |
| **10.2:** Spouse or Other Parent (If living in the home) First/ M.I. Last Race Code | ☐ | | | | SSN DHS ID | ☐ | ☐ | ☐ Individual or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Tax Dependent ☐ Non Filer | ☐ Individual or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Tax Dependent ☐ Non Filer |
| **10.3:** List children / tax dependents First/M.I. Last | ☐ | | | | SSN DHS ID | ☐ | ☐ | ☐ Tax Dependent of Household Member ☐ Tax Dependent of Someone Outside the Household ☐ Non Filer | ☐ Tax Dependent of Household Member ☐ Tax Dependent of Someone Outside the Household ☐ Non Filer |

# Application for Health Insurance
# PART 1

- American Indian / Alaskan Native Information
- Read Carefully Before Signing

# Application for Health Insurance

**American Indian & Alaskan Native Information ( See instructions)**

**11.** Complete the table below for anyone in your household named in question #10 who is of American Indian or Alaskan Native descent. Skip this section if no one named in question #10 is of American Indian or Alaskan Native descent.

| Name of Person | Tribe Name | Check if Tribal Member | Check if Descendant | Check if eligible for Indian Health Services |
|---|---|---|---|---|
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ |

**Read Carefully Before Signing**

**If you are purchasing unsubsidized health insurance through a Qualified Health Plan (QHP), sign here and do not complete Part 2 of the application.**

**By signing this application you are agreeing to the Exchange sharing your information with other state and federal agencies.**

**12. SIGNATURE:**_____**DATE:**_____

# Application for Health Insurance PART 2

- Health Insurance Information
- Children's Health Insurance
- Unpaid Medical Bill Information
- Alien Emergency Medical Information
- Pregnancy Information

# Application for Health Insurance

**If you want to be considered for subsidized health insurance through Advanced Premium Tax Credits (APTC) or Apple Health, you must complete Part 2 of this application.**

## PART 2

**Health Insurance Information**

**13. a.** Do you or anyone you are applying for have health insurance? ☐ Yes ☐ No (i.e. private / employer sponsored, Medicare, Tri-Care)

If yes, list the name of the insurance company(s) or employer(s) providing health insurance:

| INSURANCE COMPANY OR EMPLOYER NAME | INSURANCE COMPANY OR EMPLOYER PHONE NUMBER | POLICY NUMBER / GROUP NUMBER | SUBSCRIBER'S NAME | SUBSCRIBER'S DATE OF BIRTH |
|---|---|---|---|---|
| | | Policy # _____ Group # _____ | | |

**13. b.** If you answered no to question 13.A., have you turned down health insurance offered through your employer? ☐ Yes ☐ No

If yes, do you know what the lowest quoted premium was? ☐ Yes ☐ No If yes, enter the amount: _____

**Children's Health Insurance**

Skip this question and go to #15 if you are not applying for a child.

**14. a.** Does your health insurance cover your children? ☐ Yes ☐ No

**b.** Have you dropped health insurance coverage for your children within the last four months? ☐ Yes ☐ No If yes, when did the coverage end? _____

**Unpaid Medical Bill Information**

**15.** Do you or someone in your household need help paying for unpaid medical bills incurred within any of the last 3 months immediately prior to the month of application? ☐ Yes ☐ No If yes, what month(s) do you need help with? _____ _____ _____

**Alien Emergency Medical Information (See instructions)**

**16.** Do you or someone in your household have a medical emergency? ☐ Yes ☐ No If yes, enter the name of the person: _____

**Pregnancy Information**

**17.** Is anyone applying for health insurance pregnant? ☐ Yes ☐ No If yes, enter her name: _____ Due Date: _____

# Application for Health Insurance PART 2

- **Gross Income Information**

# Application for Health Insurance

**Gross Income Information (See Instructions)**

This section helps us determine the amount of your household's modified adjusted gross income (MAGI). MAGI income must be used in order to determine if you are eligible for most medical insurance programs. Please answer the following questions for each household member as accurately as you can. You are not required to provide income information for individuals under 18 years of age **unless** they are required to file a tax return. We will take the information you enter and use it to calculate the MAGI income for your household. Only enter information about the types of income we ask for because some types of income, such as child support, are not used to determine your monthly MAGI income.

American Indians and Alaska Natives do not have to report income from treaty rights and other sources, including: Alaska Native Corporations and Settlement Trusts; distributions from property held in trust; distributions and payments from fishing, natural resource extraction and harvests; distributions from ownership of natural resources and improvements; payments from ownership of items that have unique religious, spiritual, traditional, or cultural significance according to Tribal Law or custom; and, student financial assistance from Bureau of Indian Affairs education programs.

You will need to enter earned income information for all members of your household who are working.

You must affirmatively answer each question unless the question is conditional.

**18. Earned Income Received From Employer:** Are you or someone in your household currently employed? ☐ Yes ☐ No

If yes, enter the name of the person employed, name of employer, and the employee's gross monthly amount received in wages, salaries or as tip income.

Do not enter self- employment income in this section. Income from S-corporations and corporations are not considered self-employment and would be entered here.

| Name of Person Employed | Name of Employer | Gross (pre-tax) monthly income (wages, salaries, tips, corporation, S-corporation) |
|---|---|---|
| | | |

**19. Self-Employment Income:** Are you or someone in your household currently self-employed? ☐ Yes ☐ No

If yes, please enter the current estimated monthly income from self-employment, after deducting your monthly business expenses.

**Note:** By answering yes to this question, you agree to provide additional documentation of income and expenses upon request by the agency.

| Name of Person Self-Employed | Name of Company | Gross monthly income after deducting business expenses (do not enter corporation or S-corporation income here) |
|---|---|---|
| | | |

**20. Employment Changes:** Have you or someone in your household experienced any of the following changes in circumstances?

- Changed jobs in the past six months: ☐ Yes ☐ No If yes, name of the person:
- Stopped working in the past six months: ☐ Yes ☐ No If yes, name of the person:
- Had an increase or decrease in hours worked in the past three to six months: ☐ Yes ☐ No If yes, name of the person:
- Started working in the past six months: ☐ Yes ☐ No If yes, name of the person:

# Application for Health Insurance

**21. Dividend Payments:** Have you or someone in your household received dividend payments from stocks or shares held in companies?
(Companies report this to you on an IRS 1099-DIV form each year.) ☐ Yes ☐ No
If yes, enter the amount received: Name of person with this income: Frequency (we will convert this to a monthly amount for you):
Enter the amount received: Name of person with this income: Frequency (we will convert this to a monthly amount for you):

**22. Rental Income:** Do you or someone in your household receive monthly income from renting a home that wasn't included in self-employment? ☐ Yes ☐ No
If yes, enter the net monthly amount after deducting the expenses incurred on a monthly basis (for example, interest payments on a mortgage, repairs, and maintenance of the property.) Name of the person with this income:

**23. Unemployment / Labor and Industry (L&I) Income:** Do you or someone in your household expect to receive unemployment or L&I income this month? ☐ Yes ☐ No
If yes, enter the type Enter the amount received Enter the frequency Name of the person receiving this income.
Enter the type Enter the amount received Enter the frequency Name of the person receiving this income.

**24. Social Security Income / Railroad Retirement Income:** Do you or someone in your household receive social security or railroad retirement benefits? ☐ Yes ☐ No
If yes, enter the income type: Enter the amount received: Name of person with this income:
Enter the income type: Enter the amount received: Name of person with this income:

**25. Veteran's / Military Income:** Do you or someone in your household receive veteran's (VA) or military benefits? ☐ Yes ☐ No
If yes, enter the amount received: Name of person with this income: VA claim number:

**26. Pension / Annuity / IRA Income:** Do you or someone in your household receive a pension payment or monthly income from a pension, annuity or IRA? ☐ Yes ☐ No
If yes, enter the income type: Enter the amount received: Name of person with this income:
Enter the income type: Enter the amount received: Name of person with this income:

# Application for Health Insurance PART 2

- **Deductions**

# Application for Health Insurance

**Deductions**

You are being asked additional questions regarding deductions the IRS may allow you because it may lower the amount of your countable income. If you do not want to answer these questions, you may still qualify for premium tax credits through the Exchange.

Note: If you answer yes to any of the following questions, you may be asked to submit additional written documentation of the deduction you claim to the agency for review.

**27. Tuition / School Fees:** If you or someone in your household attends college or higher education, does either pay tuition or other school related fees? ☐ Yes ☐ No
If yes, enter the average monthly amount paid: Who pays it:

**28. Health Savings Account:** Do you or someone in your household contribute monthly to a Health Savings Account? ☐ Yes ☐ No
If yes, enter the amount of the costs paid: Who pays it:

**29. Other Deductions:** Do you or someone in your household have any of the following expenses?
- Alimony ☐ Yes ☐ No If yes, enter the monthly amount paid: Who pays it:
- Pre-tax retirement account payments, excluding Roth IRA contributions ☐ Yes ☐ No If yes, enter the monthly amount: Who pays it:
- Monthly interest on student loans: ☐ Yes ☐ No If yes, enter an estimated monthly amount: Who pays it:
- Moving costs since January of current year: ☐ Yes ☐ No If yes, enter amount paid:

**If you answered no to question #19, skip questions 30 through 32.**

**30. Self-Employment Tax:** Do you or someone in your household pay self-employment tax? ☐ Yes ☐ No
If yes, enter amount claimed on last year's tax return:

**31. Self-Employment Retirement Plan:** Do you or someone in your household pay into a self-employment retirement plan (SEP, Simple or qualified plan)? ☐ Yes ☐ No
If yes, enter the monthly amount paid: Who pays it:

**32. Self-Employment Health Insurance Premium:** Do you or someone in your household pay a premium for private health insurance? ☐ Yes ☐ No
If yes, enter the monthly amount paid: Who pays it:

# Application for Health Insurance
# PART 2

- Application Assister / Navigator Information
- Authorized Representative Information

# Application for Health Insurance

**Application Assister / Navigator Information (See Instructions)**

Application assisters can be anyone providing assistance to individuals with the application and renewal processes at the request of the individual.

Navigators are staff and volunteers authorized by the Exchange to provide assistance to individuals with the application and renewal processes at the request of the individual. Navigators have been assigned a navigator ID number. For a list of navigators in your area, contact xxx-xxx-xxxx.

**33. a.** Is a navigator or application assister helping you complete this application? ☐ Yes ☐ No

**b.** Do you want another person to discuss this application with the Exchange? ☐ Yes ☐ No If yes, complete below.

| NAVIGATOR / APPLICATION ASSISTER NAME / ORGANIZATION | NAVIGATOR ID NUMBER | PHONE NUMBER |
|---|---|---|
| | | |

**Authorized Representative Information (See Instructions)**

An authorized representative is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes. By designating an authorized representative, you are giving permission for your authorized representative to:

- sign the application on your behalf,
- receive notices related to your application and account; and
- act on your behalf for all matters related to the application and account.

**34. a.** Are you designating an authorized representative? ☐ Yes ☐ No

**b.** Does the authorized representative have legal guardianship? ☐ Yes ☐ No

**c.** Does the authorized representative have power of attorney? ☐ Yes ☐ No

| AUTHORIZED REPRESENTATIVE NAME / ORGANIZATION | PHONE NUMBER |
|---|---|
| | |
| MAILING ADDRESS OF AUTHORIZED REPRESENTATIVE | E-MAIL ADDRESS |
| | |

# Application for Health Insurance PART 2

- Read Carefully Before Signing
- Declaration and Signature

# Application for Health Insurance

**Read Carefully Before Signing**

**Civil Rights:**

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS. Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

**Administrative Hearing Rights:**

If you disagree with a decision we have made regarding your medical coverage, you have the right to appeal the decision through the administrative hearing process. You may also ask a supervisor and administrator to review the disputed decision or action without affecting your rights to an administrative hearing.

**Health Insurance Portability and Accountability Act (HIPAA):**

HIPAA restrictions prevent us from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

**Disclosure of Information to Other State and Federal Agencies:**

- By signing this application, you are giving the Agency or the Agency's designee permission to access information in your tax returns filed with the IRS through the last five years.
- Your application information may be reviewed by other state or federal agencies.
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- The Agency may share your child's immunization history with the Child Profile Immunization Tracking System.

**Repaying the State for Medicaid (This does not apply to other types of insurance coverage):**

By law (RCW 43.20b and WAC 182-527), if you are age 55 or older AND receive Medicaid, HCA may recover from your estate (assets you own at the time of your death) to repay HCA for the costs of medical assistance and medical services. Medicare cost sharing expenses paid by Medicare Savings Program are is exempt. This is called ESTATE RECOVERY. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery (WAC 388-527-2754). Estate recovery doesn't occur until after your death and the death of your surviving spouse, if any. If you have dependent heirs, estate recovery may be delayed for some hardship reasons.

**Voter Registration**

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at www.vote.wa.gov or order voter registration forms by calling 1-800-448-4881.

**DECLARATION AND SIGNATURE**

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

| **35. SIGNATURE:** | **DATE:** |
|---|---|

# Application for Health Insurance PART 2

- **Services for Individuals with Disabilities & those Requiring Nursing Home, Assisted Living or In-Home Care**

# Application for Health Insurance

## Supplemental Information

### Services for Individuals with Disabilities & those requiring Nursing Home, Assisted Living, or In-Home Care:

**Disability Information:**

If someone in your household has disabilities, they may qualify for additional services. An individual may be considered as having disabilities if they are unable to work for at least 12 months due to a health condition. Individuals with disabilities may be eligible for the following services: xxxx, xxxx, xxxx, and / or xxxx.

1. Is someone in your household disabled? Yes ☐ No ☐ If yes, enter their name:

**Nursing Home, In-Home Care, Assisted Living Information:**

2. Do you or someone in your household need help with long-term care services because you are currently living in or expect to move to a medical institution? Yes ☐ No ☐ If yes, enter their name: Institution Type:

3. Do you or someone in your household need help with an in-home caregiver, assisted living long-term care services, DDD services, or hospice care? Yes ☐ No ☐ If yes, enter their name Where is this person currently living?

### You will be required to complete supplemental form xxxx if any of the following apply:

- You are age 65 or older or on Medicare.
- You answered yes to supplemental questions 1, 2, or 3 above.
- You wish to be considered for healthcare coverage on the basis of blindness or a disability.
- You are applying for the medically needy (MN) or the Healthcare for Workers with Disabilities programs (HWD).
- You are disabled and you want the following benefits: xxxxx, xxxxx, xxxx, or xxxx.

# Supplemental Application - Long-Term Care Services/ Medicaid Based on Age, Blindness or a Disability

# Supplemental Application

- Name and Date of Birth
- General Information
- Long-Term Care Insurance

# Supplemental Application

**Name and date of birth**

**1.** FIRST NAME MIDDLE INITIAL LAST NAME

**2.** DATE OF BIRTH:

**3.** I, my spouse, or someone in my household is applying for:

- ☐ Medical (65 or older, blind or have a disability)
- ☐ Medicare Savings Program
- ☐ In-Home caregiver services
- ☐ Nursing Home care
- ☐ Help with medical bills (from last three months)
- ☐ Healthcare for Workers with Disabilities (HWD)
- ☐ Hospice care
- ☐ Assisted Living/Adult Family Home
- ☐ Child/Family Institutional Care (Hospital/CLIP)
- ☐ Division of Developmental Disabilities Services

**General Information**

**4.** In the past 30 days, I received medical assistance from another state, tribe or other source? ☐ Yes ☐ No

**5.** I or someone in my household is a sponsored alien? ☐ Yes ☐ No Who? _____

**6.** I or someone in my household served in the military? ☐ Yes ☐ No Who? _____

**7.** I or someone in my household is the dependent or spouse of someone (living or deceased) who served in the military? ☐ Yes ☐ No

**8.** I have a dependent I have not yet included on my application that does not live with me? ☐ Yes ☐ No

If yes: Dependent's Name: _____ Date of Birth: _____ SSN: _____

**9.** I am: Single ☐ Married living with spouse ☐ Married living apart from spouse ☐ Divorced ☐ Widowed ☐

In a registered Domestic Partnership ☐ Legally separated ☐

**Long Term Care Insurance (Not needed for Medicare Savings Program)**

**10.** I/we have long-term care insurance? ☐ Yes ☐ No. Is this a qualified LTC Partnership (LTCP) policy? ☐ Yes ☐ No

If yes, please list the name of the insurance company(s) and who the policy covers.

| Insurance Company | Policy Number | Policy Holder's Name | Covered Person | Dollar value (if LTCP) |
|---|---|---|---|---|
| | | | | |
| | | | | |

# Supplemental Application

- **Additional Income Information**
- **Shelter Information**

# Supplemental Application

**Additional Income Information**

**11.** I, my spouse, or someone in my household receives income from one of the following sources:

| | WHO RECEIVES THE INCOME? | GROSS MONTHLY AMOUNT | WHO RECEIVES THE INCOME? | GROSS MONTHLY AMOUNT |
|---|---|---|---|---|
| Trusts | | $ | | $ |
| Labor & Industries (L&I or insurance benefits) | | $ | | $ |
| Child support | | $ | | $ |
| Sales Contracts/Promissory Notes | | $ | | $ |
| Gifts (cash support/gift cards) | | $ | | $ |
| Other | | $ | | $ |

**12.** I, my spouse, or someone in my household receives income from an annuity investment?*

| WHO OWNS THE ANNUITY? | COMPANY OR INSTITUTION | AMOUNT OR VALUE | MONTHLY INCOME | DATE PURCHASED |
|---|---|---|---|---|
| | | | | |
| | | | | |

*If you, or your spouse, have an interest in an annuity and you accept Medicaid Long Term Care benefits, you must name the State of Washington as a remainder beneficiary of the annuity.

**Shelter Information**

**13.** I pay a monthly shelter expense (rent, mortgage, condominium fees or property taxes) ☐ Yes ☐ No

If yes, list monthly amount: $ _____

# Supplemental Application

- **Resources**

# Supplemental Application

**Resources (Not needed if applying for Healthcare for Workers with Disabilities)**

**14.** A resource is anything you own or are buying that can be sold, traded, or converted into cash or money held by others. A resource does not include personal property such as furniture, or clothing. Examples of resources are:

| | | | |
|---|---|---|---|
| Cash | Mutual Funds | Houses, including the one | Life insurance |
| Checking accounts | Stocks | you live in | Burial funds, prepaid plans |
| Savings accounts | Annuities | Condominium | College funds |
| CDs | Trusts | Land | Time-share |
| Money market account | IRA | Sales Contracts | Business equipment |
| Savings bonds | 401K | Buildings | Farm equipment |
| Bonds | Retirement fund | Life estate | Livestock |

**Please list the resources you, your spouse, or anyone you are applying for owns or is buying:**

| RESOURCE | WHO OWNS | WHERE IS IT? | VALUE | WHO OWNS | WHERE IS IT? | VALUE |
|---|---|---|---|---|---|---|
| | | | $ | | | $ |

**15.** I, my spouse, or someone I'm applying for have cars, trucks, vans, boats, RVs, trailers, or other motor vehicles:

| YEAR (E.G. 2010) | MAKE (E.G. FORD) | MODEL(E.G. ESCORT) | CHECK IF LEASED | CHECK IF USED FOR MEDICAL PURPOSES | AMOUNT OWED |
|---|---|---|---|---|---|
| | | | ☐ | ☐ | $ |

**Additional Long-Term Care Resource Questions (Not needed if not applying for LTC services)**

**16.** I, my spouse, or someone I am applying for owns or is buying a home which is a primary residence:

| PROPERTY ADDRESS | CURRENT VALUE (PER ASSESSOR) | LOAN AMOUNTS OWED ON THE PROPERTY |
|---|---|---|
| | $ | $ |

**17.** I, my spouse, or someone I am applying for has sold, traded, given away, or transferred a resource in the last five years (including, trusts, vehicles, cash or life estates): ☐ Yes ☐ No If yes, complete the following:

| TYPE OF RESOURCE | DATE OF TRANSFER | VALUE OF RESOURCE TRANSFERRED | WHO WAS IT TRANSFERRED TO |
|---|---|---|---|
| | | | |

# Supplemental Application

- **Deductions**

# Supplemental Application

**Deductions**

**18.** I, my spouse, or someone I am applying for pay or are supposed to pay (check all that apply):

| DEDUCTION TYPE | MONTHLY AMOUNT | WHO PAYS |
|---|---|---|
| ☐ Child or Adult Dependent Care | $ | |
| ☐ Court ordered child support | $ | |
| ☐ Payee Fees | $ | |
| ☐ Guardianship Fees | $ | |
| ☐ Court ordered attorney fees | $ | |
| ☐ Recurring Medical Expenses (include Medicare or other health insurance premiums you pay) | $ | |

**19. I am disabled and working and have expenses that enable me to work. These are called impairment related work expenses (IRWE).** ☐ Yes ☐
**If yes, list expense(s) amount $** _____

**20.** I, my spouse, or someone I am applying for have medical expenses I owe:

| MEDICAL EXPENSE TYPE | DATE INCURRED | AMOUNT OWED | WHO OWES |
|---|---|---|---|
| | | $ | |
| | | $ | |
| | | $ | |

# Supplemental Application

- **Read Carefully Before Signing**
- **Declaration and Signature**

# Supplemental Application

**Read carefully before signing**

**Repaying the State for Medical and Long-Term Care:**

By law, if you are age 55 or older AND receive Medicaid or long-term care services, HCA may recover from your estate (assets you own at the time of your death) to repay HCA for the costs of medical assistance, medical services, and long-term care (including Medicaid personal care services). Medicare cost sharing expenses paid by Medicare Savings Program are is exempt. HCA may recover the costs for state-only funded long-term care services received **at any age.** This is called ESTATE RECOVERY. Tribal lands may be exempt from recovery.

Long-Term Care services include COPES, Medicaid Personal Care, nursing home services, adult day health, private duty nursing, and the following four DDD HCBS waivers: Basic, Basic Plus, Core, and Community Protection along with other services provided by Home and Community Services and the Division of Developmental Disabilities.

Estate recovery doesn't occur until after your death and the death of your surviving spouse, if any. If you have dependent heirs, estate recovery may be delayed for some hardship reasons.

If you are permanently living in a nursing home or other medical facility, HCA may file a lien against your property to repay the costs of medical assistance, medical services, and long-term care you received. If you return home, HCA will release the lien. HCA won't file a lien against your home if:

- Your spouse lives there.
- Your child who is blind, disabled, or under 21 lives there.
- Your sibling who has an equity interest in the home lives there and has lived there for at least one year immediately before you entered the facility.

**Administrative Hearing Rights:**

If you disagree with a decision we have made regarding your medical coverage or long-term care services, you have the right to appeal the decision through the administrative hearing process. You may also ask a supervisor and administrator to review the disputed decision or action without affecting your rights to an administrative hearing.

**DECLARATION AND SIGNATURE**

I have read and understood the information in this application. I declare, under penalty of perjury under the laws of the State of Washington that the information I have given in this application, including the information concerning citizenship and alien status of the members applying for benefits, is true, correct, and complete to the best of my knowledge.

| SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE | PRINTED NAME OF APPLICANT OR AUTHORIZED REPRESENTATIVE | DATE: |
|---|---|---|
| X _____ | _____ | _____ |

# Additional ME 2014 Resources

- **HCA Medicaid Expansion 2014 Website**
  http://www.hca.wa.gov/hcr/me

- **Contact Us**
  medicaidexpansion2014@hca.wa.gov